**THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA**

**Report by Michelle Roberts**

**2010 Churchill Fellow**

The Nancy Fairfax Fellowship to investigate strategies that contribute to creating a classroom environment where school aged children who have experienced emergencies and disasters are able to maintain their social, emotional and academic trajectories.

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## 

## ABBREVIATIONS

ACATLGN Australian Child & Adolescent Trauma, Loss and Grief Network

CBI Classroom Based Intervention

CBITS Classroom Based Intervention Training for Schools

EMDR Eye Movement Desensitization Reprocessing

HATS Healing After Trauma Skills

LAUSD Los Angeles Unified School District

LSU Louisiana State University

NASP National Association for School Psychologists

NCTSN National Child Traumatic Stress Network

NOVA National Association for Victim Training

PFA Psychological First Aid

PFDL Project Fleur-de-lis

PTSD Post Traumatic Stress Disorder

TF-CBT Trauma Focused-Cognitive Behavioural Therapy

TSAC Trauma Services Adaptation Centre for Schools

SPR Skills for Psychological Recovery

SSET Support for Students Exposed to Trauma

UCLA University of California Los Angeles

## INTRODUCTION

On February 7, 2009 the State of Victoria experienced Australia’s largest ever loss of life due to a single natural disaster. The ‘Black Saturday’ fires resulted in the deaths of 173 people, of whom 20% were under the age of 24 years. Thirty-eight children lost one or both parents and 80 communities were destroyed[[1]](#footnote-1). Since that time Australia has experienced severe floods with further loss of lives, of livelihood and for some, of a belief in the safety and predictability of life in general. Australians are no strangers to the cost of natural disasters but recent events have brought about recognition of the need, in addition to the rebuilding of the infrastructure of communities and people’s lives, for community recovery strategies that aid in psychological healing after such terrifying and traumatic events.

As well as community recovery there needs to be psychological recovery for individuals, families, school communities and other groupings of people, interventions for individuals that help them to manage the experience and the responses elicited. After the bushfires, many such programs were implemented and schools played an important part in educating parents and students about the common responses to stress, trauma and loss. They also provided an environment where a semblance of normality could be restored, where teachers knew how to provide safety and security for students, even when they themselves were struggling with the magnitude of the experience. A *trauma sensitive* classroom is one where the adults are informed and the behaviors of the child are interpreted through understanding of the experience and what it has meant for the child and their family. A *trauma informed* teacher is able to teach students in ways that accommodate their experience and provide hope that they will continue to learn. It is not uncommon for children to lose their way after exposure to such adversity. It is the significant adults and their school community that can help them to move on; not to forget but to be able to choose when they think about the experience and to grow from it.

For school communities to be able to provide this level of support they must be supported in their own recovery, in their knowledge and understanding of the impact of the event and its consequences and of the specific needs of children in such events and after… for however long it takes. Increasingly schools are being seen as the best option for delivering psychological support to children and adolescents after mass adversity and potentially traumatic events.

This Churchill Project was primarily concerned with what we can do to minimize the damage caused by to the developing child as a consequence of exposure to disasters and other traumatic events.

I am indebted to the Winston Churchill Trust and especially the Fairfax Family Trust for the opportunity to explore strategies that contribute to creating a classroom environment where children who have been exposed to such potentially traumatic events are able to continue to grow, develop and learn in a positive manner. The Nancy Fairfax Fellowship allowed me to travel to Israel and the United States of America, to observe and witness strategies developed for use with children and to speak with experts in this specialized field of trauma psychology.

I would like to acknowledge the support of my referees, Professor Beverly Raphael and Dr Vicki Trethowan, experts in their own right in this field, who have provided unending support and encouragement.

I would also like to recognize the generosity of those people who I met whilst travelling and studying. All made time to listen and share, to introduce me to others with the same areas of interest and to help me to make linkages between their experience and that of Australia. Thank you also to my family for understanding my passionate belief in the need to support children through times of stress and trauma and for their support.

## EXECUTIVE SUMMARY

**Michelle Roberts,** PO Box 646, Woodend. Victoria 3442

Psychologist & Director of Student Wellbeing, The Kilmore International School.

**Churchill Fellowship: The Nancy Fairfax Fellowship to investigate strategies that contribute to creating a classroom environment where school aged children who have experienced emergencies and disasters are able to maintain their social, emotional and academic trajectories.**

Highlights included:

* Participation in the Trauma and Resilience: Theory and Practice from the Israeli Perspective - Winter Course, Hebrew University, Jerusalem
* Programs to support recovery and public mental health in New York and the valuable research being undertaken and disseminated
* The strong linkages between researchers, clinicians and practitioners in Miami, New Orleans and Los Angeles
* Project Fleur-de-Lis & LAUSD programs
* NCTSN: the integrity of their work and commitment to child trauma
* The generosity and hospitality of professionals in the child trauma field
* Participating in an Active Shooter exercise at UCLA
* Visiting Grade 3 at Primary School 123, Brooklyn and The Regional Crisis Team Putnam/Northern Westchester BOCES

**Conclusions and recommendations:**

Exposure to traumatic events frequently damages the trajectory of normal development for children. Such events may be chronic in nature such as violence within the home or abuse or the y may be single incidents that have life-long impact. As a nation that experiences natural disasters frequently Australia needs to have well developed and evidence based strategies and practices in place to assist children to recover from the impact of such events.

A framework for establishing a child trauma sensitive culture requires commitment at many levels within Government as well as within the education sector.

Child mental health can be protected and enhanced through school based programs that are delivered by trained professionals and that are targeted to need and based on assessment.

Australia needs an adequately resourced national body to oversee the development of programs, research, training, resources and assessment to enhance professional expertise before the next major event to impact on the mental wellbeing of children and to work with those children for whom trauma is an everyday part of their lives.

## PROGRAMME

**January 2 – 18 2011**

Rothberg International School

Hebrew University, Jerusalem

Trauma and Resilience: Theory and Practice from the Israeli Perspective - Winter Course

* Participant in a program that explored the latest developments in the trauma field, including field visits to a school based community recovery program and a pre-school intervention program for young children living in the shadow of ongoing war and terrorism. Attendance was supported through a scholarship awarded by the Australian Friends of The Hebrew University of Jerusalem.
* Presentation to the group of work conducted after the Victorian Bushfires 2009 with school based communities.
* Follow up interviews with experts from the Israel Centre for the Treatment of Psychotrauma including Dr. Naomi Baum, Dr. Danny Brom and Dr. Ruth Pat-Horenczyk.
* Visit to Yad Vashem, the Holocaust museum

**27th of March 2011**

* Visit to The World Trade Centre site & tour.

**28th of March 2011**

* Visit to the Tribute Centre, World Trade Centre & personal tour with Denise and Paul McFadden
* Review of school based curriculum around the WTC attacks.

**29th of March 2011**

* Meeting with Dr. Lynn Allen, Assistant Director of Special Education & the Guidance & Child Study Centre and the Regional Crisis Team at Putnam/Northern Westchester BOCES.

**30th of March 2011**

* Meeting with Dr. Kimberley Hoagwood. Director of Research on Child and Adolescent Services for the Office of Mental health- New York. Professor of Clinical Psychology in Psychiatry, Columbia University.
* Attendance at team meeting for The Centre on Implementation of Evidence Based Practices for Children in the State System/Centre of Child and Family Mental Health: Research and Effective Practices; Division of Mental health Services and Policy Research.

**31st of March 2011**

* School visit, Primary School 123, Brooklyn

**10th of April & 11th of April 2011**

* Meeting with Dr. Annette La Greca. Professor of Psychology & Paediatrics, Director of Clinical Training, University of Miami.
* Presentation to Doctoral Candidates on Psychosocial Recovery in Victoria Post Bushfires.
* Meeting with Dr Wendy Silverman and Scott Sevin – Disaster recovery and community strategies

**April 12th 2011**

* Meeting with Dr. Joy Osofsky, Professor, Department of Paediatrics and Psychology & The School Based Intervention Team LSU New Orleans.
* Meeting with LSU Department of Psychiatry – Trauma services in schools
* Participation in school based intervention team meeting with Dr. Howard Osofsky & Dr. Joy Osofsky
* Attendance at Doctoral Students’ case management meeting and seminar

**April 13th 2011**

* Meeting with Dr. Douglas W. Walker, Clinical Director/Clinical Psychologist Mercy Family Centre& Director of Project Fleur-de-lis, New Orleans.
* Tour of New Orleans cemetery
* Tour of Hurricane Katrina impacted communities and exhibition

**April 16th 2011**

* Phone Interview with Dr Rebecca (Becky) White, Professor Child and Family Development. LSU AgCentre, Baton Rouge, Louisiana

**April 18th – April 25th 2011**

* Meetings with expert members of National Child Traumatic Stress Network (NCTSN). University of California Los Angeles (UCLA).
  + Dr Melissa Brymer, Director, Terrorism & Disaster Programs.
  + Dr. Robert Pynoos, Co-Director
  + Dr. Alan Steinberg, Associate Director
  + Dr. Christopher Layne, Director of Treatment & Intervention Development
  + Dr Kelly Decker, Program Coordinator
  + DeAnna Griffin, Project Coordinator
* Presentation to NCTSN team
* Participation in teleconference for school trauma network with Dr. Kelly Decker
* Meeting with Dr. Greg Leskin, Assistant Director Project Director: Focus for Military Families UCLA Semel Institute for Neuroscience and Human Behaviour.
* Participation in UCLA Active Shooter exercise
* Telephone meeting with Dr. Robin Gurwitch, Program Coordinator at the National Centre for School Crisis and Bereavement/professor at The University of Oklahoma Health Sciences Centre

**April 22nd 2011**

* Meeting with Dr. Marleen Wong, Assistant Dean Field Education/Clinical Professor, University of Southern California
* Meeting with Joshua Kaufman, Psychiatric Social Worker, School Mental health Services, Los Angeles Unified School District.

Main Body

## BACKGROUND

Children are considered to be among the groups most vulnerable to the effects of overwhelming and traumatic events. Disasters, terrorist attacks, war, motor vehicle accidents and painful medical interventions all have the potential to bring about trauma responses in children. A significant amount of research into child related trauma has been drawn from the abuse and neglect related literature. It is only more recently that the impact of the disasters and war/terrorism has been systematically evaluated in children and that interventions to mitigate the adverse consequences of such experiences have been developed, implemented and evaluated.

Just what such events mean to a growing person must be considered within the context of the very fact that the person is developing. Not only is their sense of the world and safety a work in progress but so is their brain. Neurological alterations, a consequence of the life saving response to threat known as fight/flight, can have life-long consequences. The arousal of the autonomic nervous system that results in increased adrenaline and oxygen rich blood to fuel muscle ability to flee and heightened awareness to track the threat and make life saving decisions within a fraction of a second are an adaptive response that keeps one alive when a threat is imminent. When this response continues after the threat has passed it becomes hypervigilance. Hypervigilance is being on constant alert for threat; a constant state of arousal can lead to burnout. A child who remains hypervigilant is generally one who has little attention left in reserve for the day-to-day necessities of learning, play and homework. Their focus, whether they choose it or not, is to remain vigilant lest the threat they now know can happen at any time and to anyone manifests itself.

Post Traumatic Stress Disorder is a term with which the general public has become increasingly familiar over the past decades. Originally, this familiarity developed from our understanding of the impact of war exposure on many soldiers. Until recently there were no separate diagnostic criteria for the identification of child trauma responses that constituted PTSD. It has only been recently that child trauma has been considered an area of specialty.

Just what the children of Black Saturday have experienced, continue to experience and the consequences of this exposure are still emerging. As a psychologist within the school sector who has worked in the field of child and adolescent trauma, loss and grief for 25 years, I can report that I am seeing and hearing of lives changed. Predictably, young children and youth who have been exposed to the terrors of disaster, are anxious, often distressed and now interpret the world through a filter of having seen too much of the challenges life can bring. Many now know that their parents can’t always keep them safe and that sometimes their parents become frightened, even hysterical and lose their sense of judgment. They know what it means to see someone die horrifically, that children as well as older people can die and that death is permanent. Depending on the developmental level of the child, this may have differential impact on their understanding of and coping with day-to-day life events.

Such exposure also results in different symptoms and consequences. For the very young child it might result in the loss of developmental milestones such as toilet training or being able to be away from a parent. For the adolescent it may result in a sense that life is short and that they are not likely to have a long life, therefore they reason, they should live life to the limit for who knows what is around the corner… this seize the day mentality may result in risk taking and at risk behaviour.

## ROTHBERG INTERNATIONAL SCHOOL/HEBREW UNIVERSITY TRAUMA AND RESILIENCE: THEORY AND PRACTICE FROM THE ISRAELI EXPERIENCE

The children in Israel grow up generally knowing that their country considers itself to be at war and that it was born from the trauma of the Holocaust. For many citizens, the threat of terrorist attack is imminent with suicide bombers targeting members of the civilian population. In addition to the exposure to potentially traumatic events, it is a requirement for all citizens to serve within the army once they turn 18 years of age. This service frequently exposes young people to threat and the sights that go with exposure to war and attack. Dr. Danny Brom referred to this situation as “providing a laboratory of stress and trauma”.[[2]](#footnote-2) Dr. Brom also spoke about the implications of survival strategies adopted by Israelis, of living with the constant threat of terrorist attacks and war. How constant threat changes the nature of individuals and the society as a whole led to discussions of intergenerational trauma and the transmission of fear, threat and violence as a means of survival.

It is interesting to reflect on what being in a constant state of perceived war does to a person and to a society. This was referred to as ‘the Israeli situation’. Every child from 18 is expected to do national service, boys for three years and girls for two. What this means is that the population shares the potential for exposure to combat and that life trajectory is put on hold for that period. The result is that many 21 – 24 year olds come back after service to pick up their educational journey. Those who do service are given subsidy support in their studies, mortgages and travel and many of them choose to take a gap year after their service to ‘get it out of their system’.

When there is news that a soldier has been killed or injured everyone holds his or her breath…. everyone. This is a case where **no one** is untouched by war related death. Yet for a society in which war related exposure to trauma is so prevalent it was acknowledged that there has been a reluctance to recognize or perhaps ‘give voice to’ the consequences of war experience and the implications for every family whose son or daughter does service. Living with the norm of sending your child off to war ‘for the greater good’ raises the question of whether exposure increases resilience to other adversity. What doesn’t kill you doesn’t necessarily make you stronger. Herzog Hospital has begun a pilot of a veterans program that aims to facilitate the reflection of time of duty and exposures within a supportive network of combat units or those with whom an individual served.

I wonder what it means for children as they grow up to know that they will be doing service and that they might die, on top of living with the ongoing sense of threat from attacks. The experts talk about how their society ‘lives on the edge’ and is aggressive and impatient. There is a *carpe diem* sense in relation to opportunities and general happiness. I imagine that this life time exposure is the norm and may not have as deleterious effects as we from a country that experiences peace as the norm might imagine. This is part of the fabric of that society.

As an outsider I noticed the armed guards everywhere, the tension between the Jewish, Muslim and Christian agendas. The sense of ‘other’ was pervasive. The uneasy coexistence of so many beliefs sits over this land like an oily film, shimmering and distorting, magnifying and intensifying.

Dr Alon Weltman identified that for soldiers and for Israeli society the most deleterious impact was noticed in the biological alterations and in capacity to regulate emotion. Many soldiers met standards for sub clinical PTSD and I know that many children and adults after the Bushfires will also meet such criteria. This begs the question about the criteria for assigning pathological levels of symptomology. If *functional impairment* were the obvious way to measure whether the detriment warrants classification then many bushfire survivors would meet a benchmark that earns further support and assistance.

Once soldiers have completed their service they are called back for a month’s training every 12 months. This further disrupts the flow of their post service life and has potential implications for the attachment of their children. Children grow up with the notion of service for the country taking precedence over themselves and the family. They learn to tolerate the tension of the possibility that their parent will die. This is the experience of pockets of our society, not our whole society. Although my Churchill Project was focused on disaster related impacts, I was reminded to consider the children in our schools who have parents serving in the defence forces.

Lessons learnt:

* Many within Israeli society are in survival mode
* The “vast experience” with such stressors has created a way of thought in Israeli society which makes exposure to these stressors normative
* I wonder about the rates of domestic violence, aggressions and fight flight reactivity along with adrenal burnout and the long term health costs of this potentiation
* Exposure to such events can leave ‘little barriers’ in a person’s natural everyday social and personal conduct
* A person might be a little more aroused and edgy or just a little less tolerant or avoidant of reminders
* The conspiracy of silence about the emotional cost of National Service allows for the ongoing exposure of generation after generation to dysregulation, fear and sorrow.

Dr Naomi Baum developed a program to work with teachers after a disaster or terrorist attack and identified the need to provide an opportunity for them to explore their own feelings and thoughts about the event before asking them to work with their children. It made me think of the work I have been doing post Victorian bushfires where, on a visit to a school, when staff were asked in small groups to speak of their experiences on ‘Black Saturday’ some spoke for the first time of their horror, the first time in nine months they had spoken about this in front of their close colleagues. Although they had worked side by side for the intervening months they had not told their story to their colleagues. Losses were spoken of in hushed tones with a sense of invading privacy or divulging secrets. This made me wonder about the need for a refuge from the reality of the aftermath and the way in which some people and children see school as an escape from the traumatic reminders; a place where they can reconnect with the illusion of safety and life before the change as a way of shoring up strengths to deal with the realities.

Psychosocial programs in schools may rupture this membrane of safety, trigger teacher distress and have adverse impact on children’s developmental and recovery related trajectories or they may teach people the skills to integrate the experience within a supportive and trauma sensitive context.

It is important to note that not all people who are exposed to such events are traumatized by them and that for many, the stress and distress are significant but with support most people can manage without developing pathology.

From the research conducted with toddlers, children, young people and their parents it is clear that “bearing witness” is an important part of ‘psychological first aid’. Bearing witness is an active process that involves attentive, non-judgmental supportive listening to the details. It is listening to the narrative without adjustment or alteration. It is what teachers, parents and counsellors often do after fires and like events. There is little discussion yet as to what cost this takes from the listener, although I know that caring for the carers is the final presentation in this course. It’s always the final presentation!

A key question is whether what we do with children in schools after disasters and emergencies helps them to manage the experience, whether it makes a positive difference. There seems to be a dearth of research measuring the impact of interventions and activities and subsequent post-traumatic growth and recovery.

Dr Ruth Pat-Horenczyk identified that those who work with children need to “improve the resolution of our observation”. That is to look more carefully at the child and their behaviour. Much of her research in the past 10 years has been with children and parents managing the threat of war and terrorism. She has worked for the past eight years with Sderot, a town that has been under rocket attack for a sustained period. They have a system of ‘Code Red’, when an incoming rocket is detected. Her research, called ‘*Growing under fire’* [[3]](#footnote-3) has aimed to develop resilience among toddlers and their parents. It is a program grounded in the community and ecological in its theoretical underpinnings. Pat-Horenczyk and her associates have found that parent distress is most predictive of child distress and that the therapist should ‘mother the mother so that the mother can mother the child’[[4]](#footnote-4). In such communities, “the child grows too early”[[5]](#footnote-5).

It seems to me that there is universality in parenting dilemmas during and after traumatic events that isn’t event related but purely about parenting under threat. In Sderot, a teacher and songwriter wrote a song for children to sing when a Code Red was declared. It told the children to run to safety, that their heart goes ‘boom, boom’ when they are scared, that soon it will be over, when they hear the boom of the bomb or rocket fall, then they can breathe deep, shake their legs out, laugh and cheer that it’s over. The song has treatment links with interventions such as Eye Movement Desensitization Reprocessing (EMDR), endorphin release and self-modulation as well as teaching mastery and control of fear responses.

The NAMAL Program for parents and toddlers in Sderot, known as “Parents Place”, was developed with the intention to strengthen the capacity of parents living under continuous threat of missile attacks. Being a confident parent while living with adversity is difficult! Parents may continue to parent in ‘survival mode’ even when the threat has gone, continuing to attend to their own psychological coping and physical reconstruction needs in the absence of emotional recovery. Parenting in survival mode impacts on parenting capacity; the Namal Parents Place program aims to help parents reconnect with their children and to build capacity and skill within the wider community.

## Parents Place program - Background

The program is based on a model developed by Jewish Family and Children Services in San Francisco and aims to provide support and knowledge for parents coping with the challenges of raising children in times alternating between threat and normality.

The Israel Centre for the Treatment of Psychotrauma (ICTP) provides intervention for parents, realizing that to best provide for young children in stressful life circumstances they needed to address the needs of the parents. The program has been developed in conjunction with parenting professionals and play therapists and is designed to equip parents with knowledge and practical tools for coping with stressful and traumatic experiences as parents of young children.

The “Parents Place” program has five different modules of intervention:

1. The NAMAL Program – Make room for play
2. Group therapy for parents
3. Weekly Q & A session
4. A monthly public lecture series
5. Training for pre-school educators

**The NAMAL Program – Let’s make room for play[[6]](#footnote-6)**

The program is designed to support parents who are parenting “in the shadow of trauma”[[7]](#footnote-7) and is based on the premise that supportive and empathic adults can fill a number of emotional and adaptive roles for the traumatized child. For children who have been exposed to traumatic events, talking to an adult can:

* help base the experience in memory
* help the child comprehend and interpret the experience
* reform misconceptions
* provide information on means of coping, dealing with and adjusting feelings

## Program Objectives

The program aims to improve the emotional and cognitive functioning of young children through play activities that involve both the parent and the child. The parent learns how to play in new ways with their child; they are encouraged to ‘have fun’ again. For the child, this allows them to experience their parent in a happy way, where the parent is with the child, interested and loving. This intervention provides structure, security, emotional warmth and trust in a space that allows the traumatic event to be spoken of and acknowledged. The cornerstone of the program objectives is to strengthen the child-parent bond. A strong parent-child bond provides a protective base; promotes independence and self esteem and allows parents and children to learn how to tolerate ‘positive feelings of tension and anticipation’ and ways to self soothe and modulate uncomfortable and fearful tensions and anxieties.[[8]](#footnote-8)

**Lessons Learnt**

1. Israel has developed strategies to manage the ongoing threat of terrorist attacks and war that aim to strengthen parents’ ability to parent
2. Programs designed to reduce psychological harm from exposure to traumatic events are most successful when they involve the parents and teachers
3. Programs incorporate skills development in mastering the fears and arousal responses

## UNITED STATES OF AMERICA

## The Regional Crisis Team at Putnam/Northern Westchester BOCES & Dr. Lynn Allen, Assistant Director of Special Education & the Guidance & Child Study Centre.

“Every school should have the internal capacity to provide appropriate, effective intervention in a crisis, some traumatic events require outside assistance from professionals with specific expertise in crisis intervention”.[[9]](#footnote-9)

The Regional Crisis Team at Putnam/Northern Westchester BOCES is led by Dr. Lynn Allen, Assistant Director of Special Education and the Guidance and Child Study Centre. The team is a voluntary group of school based mental health professionals that was established after the Columbine High School massacre in 1999, an event that marked a turning point for educators, emergency management agencies and child/school health professionals around the world. Although Columbine wasn’t the first incidence of school shooter violence, it was the event that initiated policy review and research into identifying those who might be likely to perpetrate such horror, management of identified disaffected and dangerous youth by school mental health providers, security and administration as well as protocols for response to such events and strategies for managing the aftermath in a school setting. [[10]](#footnote-10) [[11]](#footnote-11)

The Regional Crisis Team aims to provide “best practices intervention”[[12]](#footnote-12) support to schools during and after a critical incident. Each school defines what they consider to be a crisis and when they feel they need additional assistance. There is no pre-ordained trigger for the team to come into a school and provide expertise and support. The team identified suicide of either a student or staff member as one of the more difficult events to respond to where the sense of shame often meant it was kept quiet and low key, another difficult event to respond to was a ‘cross burning’ where an African American family found a cross set alight on their front lawn. This sparked concerns of race conflict. Another ‘risk’ was seen to be the nuclear power plant, which was quite near the school in which we met. In the context of the evolving radiation issues in Japan at the time, there was a degree of nervousness about the safety of the site and discussion of drills for evacuation plans.

Originally members trained through NOVA (National Association for Victim Training) and they acknowledge that ongoing school specific evidence based training is a challenge, especially given that school crisis response and intervention are not core day to day business. After each crisis response members of the wider team, that is not just those who provided the response, come together to review the intervention. This operational debriefing forms part of their ongoing training.

The Putnam/North Westchester team responded to the impact of 9/11 World Trade Centre attacks through supporting distressed staff and students and by facilitating participation in psychoeducational activities under the auspices of NASP (National Association for School Psychologists). NASP provided resources, advice and support to those in schools in the immediate vicinity of the World Trade Centre.

The team members spoke at our meeting of how their team had grown over time to include professionals from community agencies and that the interagency collaboration had strengthened their capacity to respond to the needs of children and staff in schools. What’s more, working with other agencies and groups within the wider circle of the child’s life meant that children and parents had support in all the spheres of their lives, not just school. This allowed for a trauma informed community where the needs of children who had been exposed to a critical incident were understood or at least acknowledged.

Interventions after a school based critical incident or one that occurs within the community and impacts on school aged children and their community cannot be effectively managed in isolation. The Putnam Westchester Team has monthly meetings with all agencies that provide support to the members of the community. Although it took some time for school principals to become comfortable with calling in a team of mental health experts when there was a school based incident, they have come to trust the professional expertise of the members and to understand that they are there, not to take over the response to the events but to support the school leadership in guiding the school community through the challenges. Discussion ranged from how such a team with expertise can best work with the school leadership group, to gain their trust and to be able to work effectively with the school staff and students. It was agreed that being someone who ‘knows’ schools is important and that having Lynn Allen, who has been a school administrator, lead the team has given it a degree of acceptance by school principals.

**Lessons Learnt**

1. Providers of intervention in schools after traumatic events need to have the trust and professional respect of the school leadership.
2. On-going training in evidence based practice is difficult for such teams when the work is not their day to day work
3. The regional staff provide short term, acute intervention strategies to schools
4. The program is not part of a wider coherent plan
5. Parents do not become involved in school based interventions after an incident
6. There is no formal assessment of the impact of the intervention
7. Mental health interventions in schools are influenced by the political climate

Schools, like all groups and organisations have a unique culture. The school culture of ‘duty of care’ requirements means that most school principals are mindful of their responsibility in not only helping students to cope with a disasters, emergency or unexpected death but also to maintain the learning focus of the school. Sometimes this creates a tension between the psychosocial recovery programs for students and the learning imperatives of the school staff.

The political climate was seen to influence the capacity of the Crisis Response Team to assist students after a crisis. The Global Financial Crisis had resulted in many schools struggling financially and with a political/educational environment that had a back to basics underpinning. There was a perceived pressure to not spend too much time on recovery activities and an expectation that children were not to be seen to be more upset by the crisis and psychological interventions. The mantra was not to ‘open up emotion’. This placed the team under pressure to balance the need of children to express their grief and distress and the expectation that parents and staff shouldn’t be exposed to children’s distress.

There was hope that new legislation might make allowances for ‘character education’ and in doing so, establish a climate where psychological intervention and psychosocial recovery after crises would be seen as helpful. This emerging legislation is rooted in the increasing concern with cyber bullying and social networking being used in damaging ways.

A crucial factor that was evident from this meeting was that parents were not seen to be active players in the school programs.

## Dr. Kimberly Hoagwood, Director of Research on Child and Adolescent Services for the Office of Mental Health- New York, Professor of Clinical Psychology in Psychiatry, Columbia University.

## Evidence based interventions and using schools to deliver mental health programs

In New York and generally throughout the USA, the Surgeon General has identified schools as key settings for identifying and addressing mental health needs of youth[[13]](#footnote-13). How the political context influences policy and practices in the realm of intervention for child mental health is something that Dr. Hoagwood considers in her work at the Office of Mental Health. She acknowledged that the Global Financial Crisis had meant that her research teams were even more driven by the need to be able to demonstrate links between intervention and outcomes as a way of demonstrating accountability.

Dr. Hoagwood oversees many projects that aim to improve mental health for children through evidence-based practices. Her programs include the use of ‘Family peer advocates’ who have a formal and paid role within the mental health system, they have proved to be an important way to connect with parents, developing trust and credibility for the program and increased compliance with the intervention strategies. They are trained in generalist mental health skills which include specific skills such as listening rather than problem solving, boundary setting, ways in which to facilitate the telling of the story, prioritizing issues and linking in with agencies as required. In other programs, parent connectors have a role in providing support for parents in a phone call once a week, again this additional support has been found to increase the likelihood of the child continuing to participate in the program and to support change within the family and the child.

## A good school based mental health program

Dr. Hoagwood is of the belief that schools play an important role in providing mental health programs to children. Within a school setting such programs can be implemented consistently, include parents, teachers and peers in supporting the skills and changes brought about through the interventions and can be tailor made for the developmental level of the children. Such programs are most successful when they are integrated into the general classroom curriculum.[[14]](#footnote-14)

Amongst the Hoagwood programs are specific school based mental health programs including “Improving evidence based trauma care in schools through community partnership”. The research is to be undertaken by Dr. Erum Nadeem and is to develop a model for “Increasing the fit between an evidence-based treatment for trauma related PTSD symptoms and the goals and priorities of school stakeholders”[[15]](#footnote-15).

## Evidence Based Intervention

Fundamental to this study and that of my Churchill is the question of what constitutes an evidence- based intervention within the field of child trauma. Hoagwood believes that an evidence-based intervention is one which has been tested through a control group design or through multiple single case design studies, where there is standardised outcome assessment post intervention and where one can demonstrate consistent positive effects of the intervention. She also includes the requirement of there being a manual or standardised training material for replication.

## What’s needed when introducing Evidence-Based Practices into schools for mental health programs?

A program that aims to mitigate traumatic exposure should begin with screening, assessment, guidelines and protocols for all interactions. These things should be developed before the need to implement such a program or intervention in a school based population.

**Lessons learnt**

1. There needs to be a workforce of teachers, school based mental health professionals and clinicians who are trained, skilled and available, this often requires ‘re-tooling’ of the workforce. That is, equipping them with new and solid skills to work within this context.
2. The knowledge that such workers need would include:
   1. How to identify risk factors and protective factors
   2. What are effective intervention modalities and
   3. How to implement them with fidelity, (that is how they are meant to be used and how the evidence has indicated they should be used)
   4. Measuring outcomes and the influence of the intervention in changing behaviours positively
3. The challenge is to use evidence to improve practices and policies in child disaster recovery interventions and to provide leadership within the child trauma community, for this to happen there needs to be a system developed to implement and integrate the interventions and practices.
4. Schools allow children access to mental health interventions and provide a framework for applying skills learnt
5. School based interventions have a greater take up and success rate than clinical services for youth[[16]](#footnote-16)

Dr Hoagwood stated that it takes 20 years for a proven intervention to become part of routine intervention and that there are many barriers to implementing effective practice in the real world.

## New York and the World Trade Centre

As the tenth anniversary of the World Trade Centre and Pentagon attacks draws near there is still a palpable sense of grief, trauma and loss. The loss is not confined to those who had loved ones die but of a sense of safety and a belief in the predictability of day-to-day life. Many of the children who witnessed the attacks directly or who lost parents or family in the attacks are continuing to live with the consequences. For some it has meant that they have developed PTSD, others have had their lives derailed. A husband and wife team, Denise and Paul McFadden, who were part of the firefighter fraternity, led the personal tour of the WTC in which I participated. They spoke of how the events of that day unfolded in their lives and of the 300+ funerals they attended in the following 12 months. Denise is a retired schoolteacher and her representation of the impact of 9/11 was cognisant of the consequences for young people. During the tour there were times when she suggested to parents that they might want to exclude their children from hearing the narrative, some things believed to be too confronting for the children to hear. Times when she spoke about the people who jumped from the burning buildings only to land on those who had just escaped or those who killed themselves after the horrifying experiences were examples of content that was deemed inappropriate for the children. The children in the group were aged from toddlers through to young teens. It is interesting to think about where a culture draws the line as to what children should be exposed to and what they should not.

It has been reported that children exposed to the WTC attacks are at greater risk for mental health issues than others. Behaviour problems, post-traumatic stress disorder, anxiety and depressions have all been identified in children after exposure to traumatic events.[[17]](#footnote-17)

## Miami and New Orleans

## Lessons learnt from Hurricane Katrina, Gustav and the Gulf Oil Spill

Dr Annette La Greca has researched interventions for children and adolescents after disaster related exposures. She has worked to develop the integration of evidence-based practices into the school system and in developing resources that can be used by parents and teachers to help children understand the events and the symptoms that they are experiencing. Partnering with Scott Sevin, she has produced several booklets aimed at psycho-education such as ‘After the storm’[[18]](#footnote-18), and ‘Helping children cope with the challenges of war and terrorism’[[19]](#footnote-19) to mention just two. One of her stated goals is to guide the translational implementation of research. Even though there is increasing research around interventions in schools after disasters, there is more work to be done in ensuring that the programs are implemented in the way they have been designed and that outcomes are measured and evaluated. Sevin’s work also aims “to provide a bridge between scientific research and school based intervention”.[[20]](#footnote-20) There is yet to be research that provides evidence of the use of the psychotherapeutic/psychoeducational booklets and research on effectiveness often lags behind the adoption of promising practices.

La Greca notes that school based interventions are not for everyone and that an assessment or triage process should identify which students need intervention that is beyond that of the existing supports within their environment, such as family and friends and their own coping skills. Programs might begin with a universal psychoeducational or psychological first aid intervention, followed by selected interventions for students with ongoing distress and then targeted programs for those who are assessed as developing disorders such as PTSD or anxiety and depression. She advocates for stepped care and family inclusive interventions like many of the other experts interviewed.

She also acknowledges that teachers are not always the right people to be implementing such programs and that frequently they are also struggling with the same post disaster challenges as the students. This view was also reinforced by Dr Baum in her work both in Israel and after Hurricane Katrina; she noted that the school system is well placed to mitigate traumatic experiences but that the first question is to ask of the teachers themselves how they are doing and acknowledging their losses in the disaster. This is the first step to providing support to students and the school community. Baum, through her Building Resilience Program, asks teachers to take stock of where they themselves are at and to identify what it is that has been helpful in their own coping, encouraging them to focus on their own resources and meaning making of the experience. This then allows them to be in a more resilient place before they begin to facilitate the recovery of their students. Some teachers after Black Saturday stated that they felt that their own loss and grief was expected to be shelved while at school and that their school based professional role had to take priority over that of their families and selves.

La Greca’s research is moving into areas of the interplay between the psychological consequences of trauma and disaster exposure and the role that psychological distress plays in physical ill health and life style alterations that impact on wellbeing.

**Lessons learnt**

1. Teachers aren’t always the best people to be implementing programs in schools
2. Teachers’ psychological needs and wellbeing must be an initial factor in recovery for students
3. Not all students need intervention and there should be assessment as to who needs additional support
4. Interventions should be part of a stepped care program
5. The implementation of research based practices in schools needs to be monitored and assessed
6. Promising practices are often adopted before they are empirically supported
7. Students should be informed of their right to opt out of intervention programs but there is an expectation within the community that psycho-educational and psychological first aid programs be provided to students

**New Orleans**

Hurricane Katrina hit the Gulf Coast on August 29th, 2005. It is estimated that 15 million people were impacted with a final death toll being estimated at 1,836, with 705 people reportedly still missing. The subsequent storm surge and collapse of levees and replacement walls led to water levels rising to 22 feet in some parts of New Orleans, enveloping whole communities. More than 200,000 people have not returned to their homes to this day. Following Katrina, Cyclone Gustav hit just a month later and then the Gulf Oil Spill further impacted on communities.

Michelle Many has worked along with Dr Joy Osofsky and Dr Howard Osofsky in responding to the Hurricane Katrina disaster. She provided support to first responders and their families after Katrina had hit and the levees broke. Many of the responders and their families were accommodated on boats moored on the river. She assisted in setting up playrooms and discos for children to be kept engaged and set up schools and classes. Many people stated that they wouldn’t return to the area until schools were up and running. This became a priority and schools became a hub for recovery activities. Many of the counsellors have been able to work with children and their families over the past four years, most seeing a spike in symptoms two years after the Hurricane. Monitoring and assessment have indicated that symptoms have continued to increase in some people over five years, with the Gulf Oil spill marking another spike in symptoms in those initially affected by the Hurricane.

Responding to such a catastrophic event is a public mental health challenge. The helpers in such circumstances and their resources are generally also directly impacted, and access to the affected area from outside agencies is initially limited.

The Mental Health Team at Louisiana State University has been collecting data through school wide population data surveys over the period since Katrina. This long-term assessment of psychological impact informs intervention. Many programs are being used with school populations including the HATS program, TF- CBT, the Heroes program, and various resilience building programs. Some of the programs aim to enhance social connection whilst others are targeted to address symptoms of distress and trauma response.

Their research had indicated a steady decrease in symptoms reported until recently with the oil spill; this resulted in a doubling of student requests for help. It was hypothesized that some students found it easier to ask for help after the oil spill because there was someone who could be blamed for the event. Natural disasters are often no one’s fault and it seems that there is a belief that to feel ongoing distress is not warranted, whereas if there is a human error or intent that has brought about the disaster, one has a right to feel aggrieved and affected. When asked about the role of teachers and the impact of the events on the teachers, it seems that they had tried to collect data about the teachers own wellbeing but that few responded. The program from LSU did provide seminars on self-care for teachers and posters on warning signs for staff was part of the overall intervention.

In some of the school communities, mental health clinics have been established alongside the school where specific and targeted therapy is provided to students either individually or in groups, this is conducted by the clinicians from LSU and other mental health agencies. What they have found is that if the adults in children’s lives believe that the child is getting help, then they have more hopeful expectations of their children and over all this results in better outcomes. It is part of restoring hope and future expectations.

Many students were forced to attend schools in states and areas other than their own. These children showed significant distress, with symptoms spiking at three years. It was theorised that at this point it seemed like this ‘temporary’ situation was to be their life forever and that they despaired of ever returning to their own locale. The displaced children generally had trouble fitting into their new schools and were seen as being unruly and uneducated. Many were not wanted in the new schools and felt further alienated and isolated.

Additional research has been tracking the long term outcomes for health amongst oil spill affected communities. Physical health consequences of chronic stress and exposure to toxins in the environment are emerging, adding to the adverse childhood experiences of the children. Dr Howard Osofsky has noted an increase in myocardial infarction after Hurricane Katrina with some children suffering additional loss due to parent death.

LSU is also involved in supporting families of defence personnel. They have been attending the ‘wounded warrior’ support sessions where young men and women who have returned home from active duty with severe injuries are reintegrated into the family.

## Project Fleur-de-lis

The challenge to establish a coherent, planned and informed response when all infrastructures have been damaged was met by Project Fleur-de-lis. This is a school based mental health program that is designed to provide long-term care and recovery for children and their families in the aftermath of natural and man-made disasters. In partnership with the National Child Traumatic Stress Network of UCLA, schools, local health and human services agencies and national experts, the program aims to empower parents, teacher and students to “recover, renew and restore” in order to heal throughout the community.[[21]](#footnote-21)

The program provides a stepped care approach to mental health intervention and a proactive focus on addressing symptoms before they interfere with a child’s educational or social-emotional functioning. They use a non-clinical intervention model that utilizes evidence based treatment models as well as targeted interventions for students with trauma related symptomology. The model was developed in response to reports and referrals from teachers and parents that many students were exhibiting anger and distress after the hurricane. Programs such as Classroom Based Intervention Training for Schools (CBITS[[22]](#footnote-22)) and Classroom Based Intervention (CBI[[23]](#footnote-23)) along with a third strand, Trauma Focused-Cognitive Behavioural Therapy (TF-CBT[[24]](#footnote-24)) compliment the suite of child specific interventions.

Project Fleur-de-Lis (PFDL) aims to provide structured, consistent, expressive behavioural activities that can rebuild a sense of safety and control without focusing on the traumatic incident details in the intermediate and long term. The therapeutic activities focus on play, learning and creative problem solving. PFDL provides for school screening and three tiers of intervention:

1. CBI as the universal intervention that is administered school wide as a classroom- based intervention. The program aims to “stabilise traumatic stress responses, facilitate normal school activities and engage the children in creative activities around their perception of the traumatic experience.”[[25]](#footnote-25) The program has a routine of 3 stages:
   1. Opening circle
   2. Central activities and games
   3. Closing circle

It operates on the principle that only one voice may be heard at a time, which develops self- control and mutual respect. It is not unusual for parents and teachers to be overly indulgent of children after a disaster as a form of compensatory behaviour and teaching students to regain control and social skills is part of the recovery of normal expectations. The central activities and games aim to help with processing fragmented memories and physical fears surrounding the traumatic event.

\* (PFDL has since replaced CBI with Psychological First Aid)

1. CBITS is a selected intervention used with those students with lingering symptom response aimed at relieving the symptoms of PTSD, Depression and General anxiety for children exposed to trauma. It includes individual sessions and education sessions for parents and teachers.
2. TF-CBT for children with PTSD who have not responded to the school-based interventions. The intervention addresses difficulties encapsulated by the acronym ‘CRAFTS’ which represent the domains of: Cognitive, Relationship, Affective, Family, Traumatic behaviour and Somatic problems and is a community-based intervention.

PDFL has provided intervention to a large number of students and schools using evidence based programs that are tiered to student need and symptoms. Students are triaged through a process of consultation meetings and Principal/Counsellor focus groups. PDFL has the “overarching goal of improving the quality, effectiveness and dissemination of treatment services to children and families affected by trauma.”[[26]](#footnote-26)

In addition to the program, there was training for teachers around creating a trauma informed classroom and identifying the impact of trauma exposure on learning and behaviour.

**Lessons Learnt**

1. People are reluctant to return to a disaster affected community until schools are available to operate
2. Disaster related symptoms may not emerge for years and may continue to increase over time
3. If we can screen in schools for academic benchmarks and required interventions then why not for social emotional wellbeing?
4. Screening allows for identification of ‘the quiet sufferers’ and for reaching out to kids
5. Requests for specialist help doubled after the oil spill
6. Measuring teacher wellbeing is important to the wellbeing of the students but many do not want to be part of the measurement of their psychological wellbeing, this may be due to perceived concern about confidentiality and implications for their ongoing employment
7. Displaced children had secondary adversities that added to their symptomology
8. Working with symptomatic children provides parents and teachers with the belief that the students can recover and restores hope for the future
9. Interventions should be goal directed
10. Hurricane Katrina provided an opportunity for the education system to reinvent itself- the school system took the opportunity to redevelop
11. Many children had previous trauma experience before Katrina and the hurricane retriggered early responses
12. A plan for intervention after a mass event would include
    1. Resume school as soon as able
    2. Provide psychoeducation about the psychosocial impact of disasters to teachers and then students and parents
    3. Provide adjunct capacity building curricula
    4. Provide staff capacity building
13. A clearly defined and stated model for staged intervention is required, one that is based on evidence based programs and that is applied based on screening and triage using validated child assessment tools.

## Dr Marleen Wong, University of Southern California & Joshua Kaufman, Los Angeles Unified School District

LAUSD has a crisis response management plan has been developed over time and in consultation with experts such as Dr Wong and NCTSN[[27]](#footnote-27) and RAND[[28]](#footnote-28). The District provides five levels of service to schools in relation to disaster or crises. There are designated crisis intervention teams at the school site and district crisis team intervention services that organise, train and support school, teams when the event overwhelms their capacity. This model is designed to maintain trauma sensitive and safe school environments for student and staff wellbeing. Such teams are often the first responders to psychological response during and after a crisis within a school. The LAUSD Trauma Services Adaptation Centre for Schools and Communities (TSAC), of which Dr Wong is Director, was funded in 2005 through a Federal grant to provide ‘national leadership in identifying evidence based interventions that are effective for use in schools’[[29]](#footnote-29). They offer training in CBITS to staff and recognize that it is “the only school-based early intervention program developed for ethnic minority youth, proven to be effective in addressing the mental health needs of students who have been exposed to a wide variety of traumatic events.”[[30]](#footnote-30) In addition TSAC assesses the needs and capacity of schools to deliver trauma informed services, develop models for assessment and service delivery, resources, fidelity measures and form partnerships and collaborations with other organisations with promising school based trauma practices.[[31]](#footnote-31)

The commitment to having a dedicated National Group comprised of experts that provides coordination, collaboration, evidence based practices and promising practices along with resources, training and partnerships to those who are at the coal face of crisis management and trauma response in school communities shows a significant level of understanding of the potential derailing impact of trauma in the lives of children and the benefit of intervention within school communities.

Listen, Protect, Connect- Model and Teach[[32]](#footnote-32) is a program developed for teachers to create a trauma sensitive classroom. This is a model of Psychological First Aid that uses the skills that teachers have and that provides everyday techniques for strengthening protective factors in the lives of children. It involves protecting students from being exposed to material they cannot bear, facilitating connection and developing self-help strategies, teachers are taught the benefits of modeling calm behaviour through calm routines and normative expectations. The program provides teachers with a simple guide to using their skills as educators to manage the experience, recover, and identify students who need to be referred for specialist intervention.

**Lessons Learnt**

1. Maintaining strong evidence based knowledge and skills amongst the school mental health services and staff within education sector in child trauma and crisis response coupled with resource development and supervision is able to reduce the adverse impact of such events on children’s learning and psychological wellbeing
2. This requires Government commitment, leadership and funding
3. Partnerships between researchers, clinicians and practitioners enhance delivery and intervention outcomes
4. Teacher wellbeing leads to student wellbeing

## The National Child Traumatic Stress Network – UCLA

Dr Melissa Brymer, the Director of Terrorism and Disaster Programs is part of a team of experts working to improve the standards for trauma related work and children through improving the quality of interventions and access to care. NCTSN was established by Congress in 2000 and is a collaboration of academic and community based service centers that aim to improve the standard of care and access to services for traumatized children and their families. Within a context of child development and cultural considerations, NCTSN identifies four key areas in its vision:

* Raising public awareness of the scope and serious impact of child traumatic stress on the safety and development of America’s children and youth
* Advancing a broad range of effective services and interventions by creating trauma-informed developmentally and culturally appropriate programs that improve the standard of care
* Working with established systems of care including the health, mental health, education, law enforcement, child welfare, juvenile justice and military family service systems to ensure that there is comprehensive trauma-informed continuum of accessible care
* Fostering a community dedicated to collaboration within and beyond the NCTSN to ensure widely shared knowledge and skills become a sustainable national resource[[33]](#footnote-33)

The Network oversees resource development and dissemination and coordinates national training and education along with providing expertise on specific types of traumatic events, population groups. They assist in the adaptation of treatment and delivery models for specific systems and events such as the collaboration with Australian experts in adapting and providing SPR training after the 2009 bushfires for mental health providers and with the Parenting Research Centre[[34]](#footnote-34) in adapting the Psychological First Aid programs for parents of children affected by the bushfires. NCTSN also, through its Community Treatment and Service Centers, implements and evaluates effective treatment and service approaches.

At this point in time NCTSN is unique in the breadth, integrity and linkages between research, training, intervention and resources in the child trauma arena; it provides a framework for a national systemic approach for mitigating adverse outcomes for the child adolescent population.

Over a period of seven days I met with a several members of the expert team and had conversations that ranged across specific intervention programs and strategies for specific target populations, research outcomes and models of delivery.

“ Clinical and administrative experience from International and national efforts strongly indicate that schools constitute the most effective and efficient setting in which to provide post disaster or post war mental health assistance to children and their families.” [[35]](#footnote-35) In relation to schools and intervention NCTSN advocates a tiered intervention framework that is evidence informed and that differentiates between universal broad-based intervention and symptom specific individual interventions that are either skills building or treatment focused**.** This is a stepped system of care that is matched to risk, exposure and assessed distress and dysfunction. Examples of such levels include:

1. Universal interventions such as Psychological first aid (PFA) a program intended to provide those who experience disaster with assistance in the immediate aftermath; Support for Students Exposed to Trauma (SSET Program); Healing after Trauma Program (HATS) and the Children’s Trauma Assessment Program- School Intervention Project Curriculum
2. Skills for Psychological Recovery (SPR) which is designed to accelerate recovery and increase self efficacy[[36]](#footnote-36) is a secondary prevention model developed to be provided after the initial crisis has passed.
3. Treatment models such as Cognitive Behavioural Intervention for Trauma in Schools (CBITS) program which is aimed at relieving post traumatic stress, depression and general anxiety symptoms and Trauma Focussed Cognitive Behavioural Therapy (TF-CBT) is a components based psychosocial treatment model.[[37]](#footnote-37)

Universal interventions can be implemented by teachers, parents, mental health practitioners, personal support providers and community members. The following two levels of intervention require a greater level of training and child development/mental health/clinical expertise and are best implemented in a manner that allows for privacy in the re-telling of the trauma narrative.

“Telling the worst moment needs privacy and an ability to follow through with the retelling” [[38]](#footnote-38) this cannot be done safely in a classroom with a heterogeneous group of individuals, developmental levels and experiences.

Dr Christopher Layne developed a school-based program to work with war-affected youth in Bosnia. From his experience in this context and others, in addition to research based evidence, he cites the need for assessment of functioning in affected students before the implementation of intervention. Dr Layne spoke of a ‘stepped level of care’ that matched the risk and need and different levels of intervention. He observed that teachers were ‘intimidated by the level of trauma’ their students had been exposed to and this led them to be afraid of raising the topic for fear that they wouldn’t be able to tolerate the responses. When the teachers began to assess the student distress and symptoms they felt more competent to help them in their recovery. Frequently when asked why teachers are best to provide this level of support, we answer it is because they know their students. Layne found that formal assessment gave teachers better insight into their students and assisted in their feelings of efficacy in managing to provide support. He reiterated the knowledge of Baum, Pat-Horencyzk and Brymer that it was vital that teachers were able to work through their own exposure related fears and anxiety before assisting students with theirs.

What is required is “congruence between the need of the individual and the help being offered”.[[39]](#footnote-39) Layne also noted that it was important to deploy staff to their level of expertise, that teachers are competent to use low risk, high benefit interventions and that differential responses based on impairment are best provided by mental health practitioners. In large scale events, where trained child trauma mental health practitioners are scarce, there are many paraprofessionals and teachers that can competently provide level 1 and 2 interventions, particularly if a system of supervision and mentoring is put in place. After a disaster there is almost always a shortage of trained staff, a training package that is skills focused allows paraprofessionals, with training, to implement broad-based psychosocial and psychoeducational interventions that improve functioning rather than removing symptoms. Layne also noted that adolescents are able to work well in groups around their traumatic exposures, the peer being a valuable aid in normalizing reactions and providing a support to implementing skills and strategies for recovery.

Lesson learnt

1. It is necessary to triage children after a disaster according to severity of need
2. Staff must be deployed on the basis of expertise
3. Intervention must be tiered and participation in interventions must be based on assessed need
4. Teachers are able to support students’ recovery through universal interventions
5. Teacher must be provided an opportunity to work through their own disaster exposure issues before being expected to work with disaster affected students
6. All levels of intervention require monitoring and supervision for fidelity

## Project Focus

Project Focus is a program designed to help families to address the stress related to deployment and is part of a collaborative partnership between NCTSN and the US Navy. Dr Greg Leskin heads up the program and conceptualizes it as a program to ‘teach about mental health rather than pathology’. This is a capacity-building, strengths-based program for families that is educational and activity based. The Individual Family Resiliency Training (IFRT)[[40]](#footnote-40) is family-centered and trauma-informed and a core principle is that of creating a family narrative to help family members understand each other’s perspectives, experiences and reactions related to each member’s deployment. The program aims to equip families with a toolkit of coping skills that includes problem-solving strategies, relaxation, communication skills, goals setting and emotional literacy. The goal is to involve families in this skills development before pathology or dysfunction develops. It is about military families staying healthy. Challenges for military families not only exist while a family member is deployed but also when they return. Educational institutions are considering how best they can support military personnel when they re-enter the civilian education system. “Transitioning back to a civilian mindset”[[41]](#footnote-41) is a difficult task for some and as with the Israeli experience of soldier return; programs are emerging to aid the transition. One such program *Combat to College*[[42]](#footnote-42) looks to create a system of support for personnel returning from duty to attend college and to assist in the development of trauma informed and sensitive classrooms.

## CONCLUSION

Children are vulnerable to negative impacts following disasters, war, acts of terrorism and events such as abuse, neglect and violence. Mass adversities that affect children have the potential to have a profound impact on the wellbeing of a society or community in general. Intervention that is evidence based, developmentally and culturally appropriate, and that is matched to level of need can reduce the adverse impact of such exposure and retain the normal developmental trajectory of the child.

It is important that there is a clearly defined and articulated model for staged intervention that is founded on evidence based interventions and where the application of which is based on screening and triage using validated child assessment tools.

## Schools

Schools provide an important systemic opportunity for providing broad-based, universal psychological interventions after a disaster and allow for a system of triage and assessment of risk and need, as well as targeted intervention. Uptake of and adherence to mental health programs in schools has been found to be more efficacious than clinical interventions. The opportunity for school aged children to return to school after a disaster or event such as a terrorist attack restores a sense of structure, normality and hope. If the school staff are impacted themselves by the events or the school doesn’t have the available resources or knowledge to provide a trauma informed and sensitive system, the school itself may become a further adversity for children. Teachers’ wellbeing after a disaster must be given priority in the psychosocial recovery plan.

Coordinated intervention in schools after traumatic events must occur at a range of levels from the relationship between the class teacher and child through to the wider public mental health system. Such systems of care must work with all the intersecting factors within the child’s psychological and social ecology to be successful, including partnering with community agencies and parents.

Programs and interventions that aim to mitigate traumatic exposure in school aged children should begin with screening of exposed children and assessment of level of need. When implementing a response to an acute event such as a disaster, assessment must also take into account previous exposure to traumatizing events that may not have been indentified or disclosed. When introducing evidence based mental health interventions to schools there should also be pre-existing guidelines and protocols for all interactions that are child respectful.

## Teachers

Teachers are able to provide support to trauma exposed children in a number of ways. By being trauma informed educators, they are able to adapt classroom relationships and curricula to accommodate the needs of the child. Hyperarousal, affect dysregulation, and hypervigilance are characteristic alterations in individuals with post traumatic stress reactions, a trauma informed teacher would be able to recognize these behaviors and their context and provide a classroom and behavioural milieu that provides opportunity for regulation and learning and that is strengths based and capacity building. Trauma specific psychoeducation and interventions such as The HATS Program, Psychological First Aid, Listen, Protect and Connect, Support for Students exposed to trauma: The SSET Program and School Intervention Project Curriculum are evidence informed manualised programs that are available to help teachers in this primary level of intervention for trauma affected classes in the acute recovery phase and intermediate recovery period.

To be able to provide appropriate care, teachers need to have been trained to develop the required skills to work within this context. They would need to:

* Be trauma informed
* Know what behaviours are characteristic of children’s trauma exposure response within a developmental framework.
* Be able to identify risk factors and protective factors
* Be able to implement programs with fidelity
* Be supervised and mentored in their work through a model of coaching and reflective supervision
* Maintain a routine of self care
* Measure outcomes and be able to identify how the intervention is changing behaviours positively

## School Based Mental Health Professionals

Schools also provide the ideal opportunity for the delivery of a second tier of intervention for children exposed to potentially traumatic events. Not all students exposed to traumatic events require this level of intervention. This next level of intervention should be delivered by school mental health professionals for students with ongoing distress.

Ideally working with other mental health providers within the community and with the support of the school principal and leadership team, school mental health professionals are able to work with groups or individual students whose level of trauma exposure and symptomology are such that there needs to be more direct therapeutic treatment. This level of intervention is directed at alleviating symptoms of distress and trauma response. Because the trauma narrative may be distressing for lesser affected student and staff, this is best done in a context of privacy and a therapeutic alliance. Only those professionals who are trained in a developmental context, with a sound knowledge of the therapeutic relationship and intervention should provide this level of intervention. There is a degree of debate as to whether work that involves the trauma narrative is appropriate for a school setting. Re-exposure to the traumatic memories may make children vulnerable when returning to class. A high degree of expertise is required to seal the open psychological wound sufficiently before the child returns to being student in a classroom. Some systems have found that having a mental health clinic alongside a school has facilitated attendance and structured the experience in a protective way. There does not appear to be research that indicates whether there is a ceiling to the level of intervention appropriate for a clinical setting within a school environment. Programs such as CBITS and SPR, along with individual targeted therapy for students who continue to experience distressing symptoms, can be implemented by these professionals.

Up to date and evidence based training is important for these professionals as is supervision and mentoring of their work and wellbeing. A model for maintaining a trauma informed, evidence based school mental health workforce has been developed by the Los Angeles Unified School District (LAUSD). It uses a cascading train the trainer framework which recognizes that training alone does not result in a sustainable skills base and sound implementation strategies. Rather, a system that utilizes scaffolding of skills, ongoing coaching and reflection opportunities that are inherent to the model is best placed to build a cohort of competent, skilled and confident professionals that can be utilized in day to day crises and mobilized for large scale events. Underpinning this system is the understanding that worker psychological safety is not just a responsibility, but vital to the success of the model.

## A system of care: Bridging the gap between practice and evidence

Creating a classroom environment where school aged children who have experienced emergencies and disasters are able to maintain their social, emotional and academic trajectories cannot happen in isolation.

In order to provide a system of care for children who experience trauma and the consequences there needs to be an overarching body that compiles the evidence and informs practice. What’s missing in Australia is a government funded and supported group of experts that makes the linkages, holds the knowledge, develops and shares the resources and which oversees fidelity of practices.

Every individual, expert or group with which I consulted during this Churchill Fellowship has a link with NCTSN in some way. They were at times partners in research or used NCTSN to disseminate their programs. For children who experience trauma, NCTSN provides the best opportunity to access quality interventions and care by their role in informing all levels of responders from parents through to clinicians and researchers. I believe that the Australian Child and Adolescent Trauma Loss and Grief Network (ACATLGN) is the nearest equivalent to NCTSN at this point in time.

The role of NCTSN in overseeing resource development and dissemination, coordination of national training and education along with the provision of expertise, adaptation of specific delivery models for specific events, cultures and systems coupled with collaborative partnerships around the world makes this organization the benchmark for child trauma evidence based, evidence informed practices.

It is my conclusion that a coordinated, funded system of expert knowledge is required to meet our professional, moral and public mental health responsibilities and to mitigate the adverse impact of trauma in the lives of children.

## RECOMMENDATIONS

1. A National network of experts in the field of child trauma be appropriately funded by Commonwealth Government to provide leadership in identifying and implementing evidence based practice, training, resources and interventions in relation to children exposed to potentially traumatic events
2. That such a network have leaders in ongoing designated roles to ensure knowledge management and integrity of implementation processes and to provide an expert skills set available for large scale events that affect the Australian child population
3. That a system of psychosocial recovery and mental health intervention skills development be established and maintained for educators and child mental health providers and that this be training occur in preparation for future disasters and emergencies
4. Schools be considered a vital system for the mitigation of trauma exposure
5. Educators:
   1. recognise the pervasive impact that trauma has on the learning ability of children and
   2. be required to be trauma informed and
   3. to develop educational plans for those children who are impacted by trauma related symptoms
   4. address the needs of trauma affected school staff as the starting point in any school based psychosocial recovery effort
6. The Education sector:
   1. adopts a model of training that is evidence informed
   2. skills the school based workforce in primary universal interventions
7. That research be conducted to gain a benchmark for the percentage of children in schools that meet criteria for PTSD and that this is used to inform programs within school learning communities
8. School mental health professionals:
   1. maintain currency in evidence based trauma interventions
   2. receive a model of training that maintains their skills set and supervised practice
9. Coordinated systems are established within the education sector to respond to acute and chronic events likely to cause trauma responses that:
   1. are evidence based,
   2. include screening and assessment,
   3. are tiered and evidence based interventions
   4. incorporate formal measurement of outcomes.
10. That systems of care for school aged children conducted in schools after traumatic events must take into account the psychological wellbeing of staff in order to look after the well-being of children

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